What is Home and Community Based Services (HCBS)?

A variety of home and community based services provided when an individual is unable to take care of him/herself without the assistance of others due primarily to chronic illness, advanced age or cognitive impairment.

- Loss of functional capacity requires individuals to receive assistance with activities of daily living (bathing, dressing, feeding) and/or instrumental activities of daily living (cooking, cleaning, shopping)
- Offers individuals choices
- Transition to Managed Care Organizations is pending CMS* approval

*Centers for Medicare & Medicaid Services
TennCare CHOICES

Current Medicaid Long-Term Care (LTC) Program

- All existing LTC enrollees have a care plan in place – services rendered and services authorized match
- HCBS* beneficiary LTC costs average less than one-third nursing facility costs, which indicates many are receiving very limited services
- Scarcity of HCBS providers contributing factor of limited services

*Home and Community Based Services
Bureau of TennCare and VSHP* Objectives for CHOICES

- Offering person-centered care planning, service coordination and support services
- Expanding opportunities and creating more choices for members and their families through development of a more flexible delivery system and promotion of alternatives to traditional nursing facility care
- Improving health outcomes through integration of acute, behavioral and long-term care services and implementation of a comprehensive quality plan

*Volunteer State Health Plan
Ancillary Services

Durable Medical Equipment (DME)/Medical Supplier Network

- Network Status
  - Commercial and TennCare DME network currently closed to new providers
  - TennCare network still on hold
  - April 6, 2009, 350 provider locations in Blue Networks P and S

- New requirements for DME providers

- Provider Directory available on company Web sites vshptn.com and bcbst.com
Durable Medical Equipment (DME)/Medical Supplier Network

- Changes to DME repair billing guidelines
- No change to BCBST reimbursement guidelines for oxygen rental
- Change to DME labor codes
- Changes to BCBST commercial DME and medical supply networks
- Changes to DME billing guidelines
- Beginning April 6, 2009, BCBST no longer requires a manufacturer’s invoice when billing A9276, A9277 and A9278

- Core 4 benefits
  - DME limited to $2500 per calendar year
  - Medical Supplies limited to $2500 per calendar year
Ancillary Services

Hospice for Volunteer State Health Plan (VSHP)

- Hospice benefits provided when:
  - Member’s provider establishes a treatment plan
  - Notification sent to VSHP Utilization Management
- Services are provided by an approved Hospice provider
- Must be provided by an organization certified by Medicare Hospice requirements
Ancillary Services

Scenarios: BlueCare/TennCareSelect Claim Denial

**Issue**

You receive a claim denial code of TR0…….Benefits cannot be provided because there was no authorization and/or referral for this service.

**Reason for denial**

No prior authorization was obtained by the provider before the services were rendered.

**Resolution**

- Submit prior authorization requests electronically via BlueAccess.
- Call Provider Service line, 1-800-924-7141.
Ancillary Services

Hospice for Volunteer State Health Plan (VSHP)

- Submit paper claims on CMS-1450 claim form or electronically in ANSI-837 format
- Must file separate line item for each date of service
- Reimbursement based on per diem rate except for room and board nursing home patients without Medicare benefits
- Use Revenue Code 0658 when filing inpatient room and board for nursing home residents with Medicare benefits
- Use Revenue Code 0651 when filing hospice visits to the nursing home
Ancillary Services

Scenarios: BlueCare/TennCare Select Claim Denial

**Issue**

You receive a claim denial code of **W26** ....... The provider must refer to the billing guidelines for proper billing.

**Reason for denial**

The provider may have filed with an incorrect Revenue Code or filed an incorrect Modifier.

**Resolution**

Review the Revenue Codes and Modifiers; correct and resubmit as a corrected claim.
Hospice for Volunteer State Health Plan (VSHP)

- Effective December 1, 2008, Revenue Code 0654 changed to 0658
- Effective May 1, 2007, one unit is equal to fifteen minutes for Continuous Home Care, Revenue Code 0652
- Continuous Home Care not reimbursable when billed in less than 8 hours (32 units) and will be capped at 24 hours (96 units) per calendar day
- File inpatient services with Type of Bill 82X in Form Locator 4
- File outpatient services with Type of Bill 81X in Form Locator 4
- Effective December 1, 2008, inpatient and outpatient charges can not be filed on the same claim form
- Hospice benefits all inclusive with the exception of provider services not related to hospice care
September 8, 2008, Bureau of TennCare implemented changes in HH and PDN benefit limits for adults age 21 years and over

HH and PDN require prior authorization

PDN is a covered benefit for members who are:

- Under age 21;
- Ventilator dependent for at least twelve (12) hours-per-day; or
- Have a functioning tracheostomy requiring suctioning AND need other specified types of nursing care which includes:
  - Oxygen (nebulizer or cough assist), medication via G-tube, PICC line or central port, TPN or Nutrition via G-tube

File PDN services using Revenue Code 0589 and T1000 HCPCS code per 15-minute increments
Ancillary Services

Home Health (HH)/Private Duty Nursing (PDN) for VSHP

Skilled Nursing Benefits:

- 27-hours-per-week maximum unless patient qualifies for Level II Nursing Home with pre-admission evaluation (PAE), then 30-hours-per-week maximum

- Prior authorization must identify if member has PAE

- Limited to only one visit up to 8-hours-per-day

File intermittent skilled nursing visits requiring up to 1 hour of time using Revenue code 0551 and HCPCS code GO154 in 15-minute increments, regardless of member’s age

File extended skilled nursing visits requiring greater than 1 hour of time using Revenue Code 0552 and either HCPCS code S9123 or S9124 in 1-hour increments, regardless of member’s age
Ancillary Services

Home Health (HH)/Private Duty Nursing (PDN) for VSHP

Home Health Aide Benefits

- Up to two (2) home health aide visits each day, limit of 8-hours-per-day

- File Home Health Aide services with Revenue Code 571 and HCPCS Code G0156 in 15-minute increments (Limited to four (4) 15-minute units or one (1) total hour)

- File Home Health Aide services with Revenue Code 572 with HCPCS Code S9122 in 1-hour increments

- If member is receiving both skilled nursing and home health combined:
  - Benefit limited to combined total of 8-hours-per-day or limited to combined total of 35-hours-per-week
  - If member qualifies for Level II Nursing Home with PAE the combined care benefit limit each week is forty (40) hours
Ancillary Services

Home Health (HH)/Private Duty Nursing (PDN) for VSHP

- Claims must be billed per benefit period, which is defined as Monday through Sunday
- Billing must occur on one claim per defined benefit week per patient
- If second claim is billed for same week, claim will be denied
- Must file each day and service as a single line item
- Benefit limits do not apply to:
  - Home health physical, occupational, or speech therapies
  - Medical social service visits
  - Home obstetrical management services
Ancillary Services

Scenarios: BlueCare/TennCare Select Claim Denial

Issue

You receive a claim denial code of X82…….The provider must refer to billing guidelines for home health services. The provider may need to file a corrected bill.

Reason for denial

Provider filed with an incorrect Revenue Code in conjunction with the CPT® code. The CPT® code billed is a higher level of care than what is authorized.

Resolution

- Provider must file the date of service span one week at a time from Monday through Sunday.
- File each day and service as a single line item per patient.

CPT® is a registered trademark of the American Medical Association
Ancillary Services

Home Health (HH)/Private Duty Nursing (PDN) for VSHP

- Adult HH nurse visit will **NOT** be extended to perform skilled nursing functions at more than one point during the day, unless skilled nursing services are Medically Necessary throughout the intervening period.

- HH nurses/aides and PDN nurses do **NOT**
  - provide general supervision, safety monitoring or sitter services
  - provide non “hands on” care such as housecleaning and meal preparation
  - transport patients

- HH nurses do not accompany adult patients outside the home
Ancillary Services

Home Health (HH)/Private Duty Nursing (PDN) for VSHP

- PDN nurse may accompany adult patients outside the home ONLY to school, work or health care appointments
- HH and PDN nursing can include patient/patient caregiver teaching and training to manage the patient’s treatment regimen
- To receive PDN, the patient must have trained family member or other caregiver who is willing to meet the patient’s nursing and non-nursing needs
- Caregiver must be present at the time the HH agency is rendering service or the agency can refuse to provide the services to the patient
Ancillary Services

Scenarios: BlueCare/TennCareSelect Claim Denial

**Issue**

You receive a claim denial code of SHD. This charge is a duplicate of a previously submitted charge for this member.

**Reason for denial**

Provider has filed a claim with CPT®/HCPCS codes filed on a previously processed claim.

**Resolution**

Resubmit claim as a corrected bill with all original charges.
Ancillary Services

Scenarios: BlueCare/TennCare Select Claim Denial

**Issue**

*You receive a claim denial code of EOB…….* Please submit a copy of the Explanation of Benefits from this member’s other insurance carrier.

**Reason for denial**

Claim was filed without the primary insurance explanation of benefits.

**Resolution**

Resubmit claim with the corresponding explanation of benefits from the commercial carrier.
Ancillary Services

Scenarios: BlueCare/TennCareSelect Claim Denial

Issue
You receive a claim denial code of S23……..This member’s coverage was not in effect on the date these services were provided.

Reason for denial
Member does not have active coverage with BlueCare or TennCareSelect.

Resolution
Review the member’s TennCare coverage on Tennessee Anytime at tennesseeanytime.org or call TennCare Provider Services at 1-800-852-2683.
Ancillary Services

Scenarios: BlueCare/TennCare Select Claim Denial

**Issue**

You receive a claim denial code of MED……Please submit a copy of the Medicare Summary Notice (MSN) so we can determine benefits.

**Reason for denial**

Claim filed without the Medicare Summary Notice (MSN).

**Resolution**

The provider must resubmit the claim with the corresponding MSN.
Ancillary Services

Questions?

1. Ask now

2. Visit with the Panel of Experts

3. Call Provider Service
   - BlueCare 1-800-468-9736
   - TennCareSelect 1-800-276-1978
   - Commercial 1-800-924-7141